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presence, and found that nalidixic acid was contraindicated if there was history of convulsive disorders. I discontinued nalidixic acid and substituted cotrimoxazole.

I am happy to report the child has been free of convulsions for the last 5 weeks. Also there is a marked improvement in personality with no evidence of hyperactivity. I am unable to predict whether the child will be free of convulsions and hyperactivity in the future.

The lesson to be learnt from this experience is to listen to the concerns and observations of parents. They are with the child all the time. We cannot remember the side effects and contraindications of drugs all the time. If in doubt don't be reluctant to refer to the text book even in the presence of patients.

G A Paul, Ngaruawahia.

The budget and certifying fitness for work

The policy of a single benefit for people temporarily excluded from the paid work force is good. Many factors hinder rehabilitation and it is unreal to pin it all on one. However the proposed greater monetary rewards for long term sickness disability will put more pressure on certifying doctors. I personally find assessment of sickness disability more difficult than accident. When one is paid by the patient, one must do the best thing for that patient, who often interprets this in purely financial terms. I find that patients, even ones I have never seen before, often resent any attempt to reassess disability. Patients will go to the doctor who takes the softest line. Clearly the budget proposals will not work unless careful consideration is given to the mechanism for determining who is fit for work.

People are excluded from the paid work force for eight reasons:

Lack of suitable employment. Very few people with long term disability are unable to do any sort of work. A caring society would reserve suitable jobs for the disabled. Certifying somebody fit for light work is futile as sporting enthusiasts prefer these jobs too. We are wedded to the concept of a forty hour working week. There would be many advantages if twenty hour week employment were more generally available. For many attempting rehabilitation this would be a much more realistic initial goal. I am dismayed at the budget target of 100 000 unemployed by the end of 1992. It would be fairer to aim at 200 000 working only twenty hours a week. Only the totally disabled should be excluded from the work force.

Lack of training and skills. These are required for most jobs suitable for people with disability. Retraining is the key to rehabilitation.

Care of other persons. Many are excluded from the paid work force by the needs of children and invalids. People often combine these responsibilities with paid employment but only if their health remains good.

Lack of motivation. I usually find that this is better described as having given up hope. What use is rehabilitation if there is no job? Where a patient has been on high wages the job that follows is likely to be lower paid. A major obstacle to rehabilitation would result from the proposed earnings related compensation for long term sickness disability.

Place of residence. People who have given up hope often attempt to make life bearable by moving to pleasant places. These are likely to be remote from rehabilitation facilities or employment opportunities. Others attempt to relieve boredom by becoming itinerant.

Congenital disabilities, illness, accident. These last three are the only causes that come into the area of expertise of the medical profession. Even here we often need the assistance of other disciplines. Seldom are medical conditions the sole causes of exclusion from the workforce. It is often impossible to say whether rehabilitation is possible unless rehabilitation has been tried.

I accept that certification by a doctor acting alone is the only practical way for short term disability. However I consider it unwise for these certificates to be renewable indefinitely, sometimes by a different doctor each time. I propose that a time limit of say six months be set. After that, assessment should be by a multidisciplinary team, whose chief function is rehabilitation. Patients should be reviewed annually. Even if the medical cause for exclusion from the workforce is unlikely to improve, the nonmedical causes may, I consider it wrong to tell clients that they are permanently useless.

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Passive smoking in New Zealand

In replying to my earlier letter (NZ Med J 1989; 102: 448) Drs Kawachi and Pearce (NZ Med J 1989; 102: 479) misunderstand some important issues. They suggest I have not grasped the purpose of meta-analysis, because I pointed out many of the studies of passive smoking and heart disease are very small. Not so; I was making it clear the overall meta-analysis would be dominated by the two large studies, based on more deaths (1852) than the other five studies combined (226), and that there were major doubts about the findings from both of these large studies.

Drs Kawachi and Pearce seem to understand my criticisms of the Maryland study [1], but not my comment on the inconsistency of the two reports from Hirayama's study [2,3]. Based on 14 years follow up and 406 heart disease deaths among female nonsmokers, Hirayama [2] reported relative risks, standardised for age and occupation, of 1, 0.97 and 1.03 according to whether the husband was (i) a nonsmoker, (ii) an exsmoker or a smoker of 1-19 cigarettes a day, or (iii) a smoker of 20+ cigarettes a day. Based on 17 years follow up and an extra 88 deaths, Hirayama [3] reported relative risks, standardised for age, of 1, 1.10 and 1.30 for the same comparisons. If standardisation for occupation had no effect, it can be estimated that the relative risks for the last 3 years follow up would be 1, 2.85 and 5.07, a magnitude of effect inconsistent with his previous results and also so large as to be totally implausible. If standardisation for occupation did have an effect, why did Hirayama not standardise for it in the later analysis?

The heart disease data, which contribute largely to the estimated 'number of deaths per year caused by passive smoking', are very unconvincing. The American Cancer Society million person study has provided the best evidence relating to spouse smoking and lung cancer [4] and it is unfortunate no similar data on heart disease have ever been presented. The study has far more deaths in nonsmokers than the Japanese or Maryland studies, and the quality of evidence is much superior.

Drs Kawachi and Pearce say they cannot specifically comment on my claim that misclassification of a proportion of smokers as nonsmokers might explain the observed association between passive smoking and lung cancer as two of my citations are to papers given at conferences. This overlooks all the other references, one to a book [5] available since 1988 which contains all the essential material. I have forwarded each of them a complimentary copy.

Drs Kawachi and Pearce quote the remark of Hill [6] that consistency of an observation across different studies increases confidence in the belief that the association is causal. This ignores the possibility of a common source of bias affecting all the studies. Misclassification of smoking habits is just such a bias. Measuring something 27 times with a faulty instrument is no better than measuring 13 times. What is needed is an accurate instrument. Until better studies are designed, estimates of deaths caused by passive smoking based on meta-analysis are likely to be seriously inaccurate.

The views I express do not necessarily reflect those of the tobacco industry. Many organisations consult me, including some tobacco companies, but the views I express are always my own, and the only reason for expressing them is to promote scientific understanding of issues of which I have expert knowledge.

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